Home Health PPS Remittance Advice Instructions

CR 1141, which contained the outpatient PPS (OPPS) instructions, also included a number of changes that apply to home health PPS. HCFA will not make additional paper remittance format changes, 835 version 3051.4A.01 implementation guide, or PC-Print changes for home health PPS. All the statements below on home health billing apply only to type of bills 32x and 33x.

As with OPPS, detailed service line level data will only be reported in 3051.4A.01 and later versions of the 835. Detailed service line data will not be reported in paper remittance advice notices, or in pre-3051.4A.01 versions of the 835 supported by the Fiscal Intermediary Shared System (FISS). The standard paper remittance advice (SPR), and the FISS version 3051.3A and 3030M 835 transactions will continue to report claim level summary data. Home Health providers on FISS who wish to receive service line level data must upgrade to version 3051.4A.01 of the 835.

As a general rule, the amount of the first payment for a 60-day episode will be reversed and withheld from the full payment made for the episode at the end of the 60 days. Payments for 4 or fewer visits will be paid using standard per visit rates, rather than under the PPS methodology. DME is not included in home health PPS payments, and must be reported in a separate line/loop for the second bill in an episode. DME may not be included in the first bill for an episode. Continue to pay DME under the DME fee schedule as at present. Continue to pay osteoporosis drug, flu injection, and PPV separately from home health PPS as 34x-type bills.

A. <u>835 Version 3051.4A.01 Line Level Reporting Requirements for the First Bill/Payment in an Episode.</u>

1. Enter HC (HCPCS revenue code qualifier) in 2-070-SVC01-01, and the Health Insurance PPS (HIPPS) code under which payment is being issued in 2-070-SSVC01-02. The HIPPS code is being treated as a type of level 3 HCPCS in this version.

2. Enter 0 (zero) in 2-070-SVC02 for the HIPPS billed amount and the amount you are paying in SVC03.

3. Enter 0023 (home health revenue code) in SVC04.

4. Enter the number of covered days, as calculated by the standard system for the HIPPS, in SVC05, the covered units of service.

5. If the HIPPS has been down coded or otherwise changed during adjudication, enter the billed HIPPS in 2-070-SVC06-02 with qualifier HC in 2-070-SVC06-01.

6. Enter the start of service date (claim from date) in 2-080-DTM for the 60-day episode. If a revenue code other than 0023 is billed, report the line item date associated with that revenue code instead of the claim from date.

7. Enter group code OA (Other Adjustment), reason code 94 (Processed in excess of charges), and the difference between the billed and paid amounts for the service in 2-090-CAS. Report the difference as a negative amount.

8. Enter 1S (ambulatory patient group qualifier) in 2-100.A-REF01 and the HIPPS code in 2-100.A-REF02.

9. Enter RB (rate code number qualifier) in 2-100.B-REF01 and the percentage code (0, 50, 60) in 2-100.B-REF02.

10. 2-110-AMT (ASC, APC or HIPPS priced amount or per diem amount, conditional) does not apply, and should not be reported for either the first or the final remittance advice for a HIPPS episode.

11. 2-120-QTY does not apply to a first bill/payment in an episode. This data element is used for home health payment only when payment is based on the number of visits (when 4 or fewer visits) rather than on the HIPPS.

12. Enter the appropriate line level remark codes in 2-130-LQ. There are no messages specific to home health HIPPS payments. There are no appeal rights for initial episode payments.

B. <u>835 Version 3051.4A.01 Line Level Reporting Requirements for the Second Bill/Payment in an Episode (More than 4 Visits)</u>

1. Reverse the initial payment for the episode. Repeat the data from the first bill in steps 1-7 in section A, but change the group code to CR and reverse the amount signs, i.e., change positive amounts to negatives and negatives to positives.

2. Enter CW (claim withholding) and repeat the reversal amount from 2-070-SVC03 in 3-010-PLB for this remittance advice. This will enable the first 60-day payment to be offset against other payments due for this remittance advice.

3. The full payment for the episode can now be reported for the end of episode bill.

a. Repeat steps A1-11 for the service as a reprocessed bill. Report this data in a separate claim loop in the same remittance advice. Up to six HIPPS may be reported on the second bill for an episode.

b. In addition to the HIPPS code service loop, also enter the actual individual HCPCS for the services furnished. Include a separate loop for each service. Revenue code 270 services will not be billed with a HCPCS, and must be reported in a separate SVC loop in the remittance advice.

c. Report payment for the service line with the HIPPS in the HCPCS data element at the 100 percent rate (or the zero rate if denying the service) in step 9.

d. Report group code CO, reason code 97 (Payment included in the allowance for another service/procedure), and zero payment for each of the individual HCPCSs in the 2-070-SVC segments. Payment for these individual services is included in that HIPPS payment. Do not report any allowed amount in 2-110.A-AMT for these lines. Do not report a payment percentage in the loops for HCPCS included in HIPPS payment(s).

e. Enter the appropriate appeal messages in a remark code data element in 2-1035-MOA and any appropriate line level remark codes in 2-130-LQ. There are no messages specific to home health HIPPS payments.

f. If DME is paid, report in a separate loop(s), and enter the allowed amount for the DME in 2-110.A-AMT.

4. If Pricer determines that a cost outlier is payable for the claim, enter ZZ (outlier amount) in 2-062-AMT01 and the amount of the outlier in AMT02. NOTE: Since this is a claim level segment, this must also be reported in 835 versions 3030M and 3051.3A.

5. If insufficient funds are due the provider to satisfy the withholding created in B step 2, carry the outstanding balance forward to the next remittance advice by entering BF (Balance Forward) in the next available provider adjustment reason code data element in 3-010-PLB. Report the amount carried forward as a negative amount in the corresponding provider adjustment amount data element.

C. <u>835 Version 3051.4A.01 Line Level Reporting Requirements for the Second Bill/Payment in an Episode (4 or fewer Visits)</u>

1. Follow B steps 1-2.

2. Now that the first payment has been reversed, pay and report the claim on a per visit basis rather than on a prospective basis. Enter HC in 2-070-SVC01-01, the HCPCS for the visit(s) in 2-070-SVC01-02, submitted charge in SVC02, the paid amount in SVC03, appropriate revenue code (other than 0023) in SVC04, the number of visits paid in SVC05, the billed HCPCS if different than the paid HCPCS in SVC06, and the billed number of visits if different from the paid number of visits in SVC07.

3. Report the applicable service dates and any adjustments in the DTM and CAS segments.

4. The 2-100-REF segments do not apply to per visit payments.

5. Enter B6 in 2-110.C-AMT01 and the allowed amount for the visit(s) in AMT02.

6. Report the number of covered and noncovered (if applicable) visits in separate loops in segment 2-120-QTY.

7. Enter the appropriate appeal messages in a remark code data element in 2-1035-MOA and any appropriate line level remark codes in 2-130-LQ.

8. If insufficient funds are due the provider to satisfy the withholding created in B step 2, carry the outstanding balance forward to the next remittance advice by entering BF (Balance Forward) in the next available provider adjustment reason code data element in 3-010-PLB. Report the amount carried forward as a negative amount in the corresponding provider adjustment amount data element.